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A CASE OF UNCOMPLICATED HYSTERIA IN THE MALE, LASTING THIRTY YEARS, WITH POST-MORTEM EXAMINATION.[1]

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REMARKS BY DR. MITCHELL.

In the *American Journal of Medical Sciences,* October 1876, I described a number of forms of spasms which I called functional after the term employed by Duchenne of Boulogne.

In these cases normal movements caused or intensified certain spastic phenomena. Among these examples I briefly described the case of Robert Connolly, which is, for many reasons, so remarkable that I propose to reprint it at length. It has passed during thirty years under the eyes or care of this present writer, of Drs. Sinkler, Lewis, Spiller, Dercum and John K. Mitchell. All of these neurologists agree as to its being a typical example of hysteria in the male. Whether through hysterical interests and the vanity of being thought unusual, or because I had been able to serve him in various ways, he volunteered to leave me his body. Within a few hours after his death I made free to use this privilege. There had been meanwhile no intercurrent malady, nothing to disturb such pathologic states as hysteria might offer. The death was sudden. The conditions seemed to be ideally perfect. This unusual chance was fully utilized. I am aware of no other case of uncomplicated hysteria in which the search for causative lesions seemed to offer such an opportunity. Its unique importance excuses the length of my report.

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[1] Read at the meeting of the Association of American Physicians, 1904.

In the winter of 1876 Robert Connolly applied for treatment at the clinic of the Infirmary for Nervous Disease.

Mr. C., white, watch-case maker, 33, married, no children, of the utmost sobriety, and until 1876 a moderate smoker, now does not smoke. His grandfather, mother and two maternal aunts had hemiplegia in middle life. His father was healthy and died at 83. Two of five sisters of Mr. C. were insane, a third had hip disease, an uncle had epilepsy, a cousin, paralytic dementia.

As a child, and indeed through life, Mr. C. was nervous, timid, gentle, reserved, and although slow at his lessons was not lacking in intelligence. At 17 he had typhoid fever, without complication or sequels. At 23 he fell twenty feet without serious results. At 25 he had sunstroke, and was insensible for two days, but had no consequences except a life-long over-sensitiveness to sun-heat. At 29 he began to have some difficulty in his delicate hand work. This was at one time a weakness of either hand, and at another a momentary spastic condition. I may here add that he was ambidextrous. The hand trouble came and went.

On Decoration Day, 1874, he grew excited and emotional after witnessing the ceremonies, and on the way home became of a sudden for a few minutes so weak in the legs as to have to sit down on a door step. From time to time this recurred, but with less severity. He became weak, stood still, felt a return of power and walked on. With these attacks came also pain in the lumbar region and the first of the cervical pain felt at times ever since.

In January, 1875, began inconstant, rather fine tremor of the left hand, only visible when the arm was flexed.

The patient when first seen by me was a rather thin, pallid man, with a nervous, uneasy, anxious look. He was a person of unusual refinement, very gentle and timid, but clearly intelligent and well pleased to be considered as an uncommon case, and over-willing for a time to exhibit the symptomatic spasms. Then abruptly, his face would change, he would lose his constant smile, and be annoyed by our curiosity.

He had at this time no organic trouble. His digestion and bowels were in good order, his senses perfect, nor had he then or later any of the ocular phenomena of hysteria. His sleep was good. The tremor of the left arm by degrees attained greater amplitude, and gradually, during the next three months, he developed the symptoms noted by Dr. Sinkler, at that time my clinical assistant.

In sleep there was no movement; when he awakened he was conscious of the left hand being rigidly closed. In a few moments it began to twitch, the fingers moving as do those of a violin player. The slightest movement of any other limb, or the act of speaking or eating, caused the left arm to execute a constant motion of striking the bed or his side, the limb being the while extended. When he arose and walked this action became more violent, and so much resembled the steady, rapid movement of a pendulum that I spoke of it once to my assistants as a case of what might be called descriptively pendulum spasms. In fact, its rhythmic regularity was astonishing. Dr. Sinkler timed it, on one occasion, as 157; and on several others I found it always 160. It was as accurate as the heart in its motion, but certain things increased either the power or the number of the motions. Thus, if he stood up, after having been seated, the number did not alter, but the force of the blow on the thigh increased remarkably.

If while standing, he elevated and extended the right hand and arm to the shoulder level, instantly the rhythm mounted to 200, and when the right arm ceased to act the number fell again to 160.

When there was no pendulum spasm he could perform with the left arm any voluntary act not involving the hand, which itself never ceased to twitch; but while the swinging spasms lasted he could execute with it no volitional act, and effort to control the limb enormously increased the spasms. Excitement and emotion and all forms of electricity added to the force of the motions, but voluntary movements of other limbs increased the number more than the force. Attempts passively to fully extend his partially flexed fingers, caused increased pain in the occiput, just as the effort to overcome rigid gastrocnemii in some cases gives rise to pain in the dorsal spine. He had power to stop the spasms by certain maneuvers. If he seized the left hand by the right, and flexing the left arm, held it, the left hand for a moment seemed to struggle with increasing violence; he tottered, his face became convulsed; there was horrible pain in the back of the head. Then as he gently released the left arm, save for a slight tremor or twitching of the unquiet fingers, it remained at rest, and might not move in violent spasm for an hour or more, and was sometimes nearly still for twelve hours. He avoided the use of one hand to stop the other, because of the great pain it caused in the head. When he stopped the hand by catching it under his leg, he had little head pain, but it was so unpleasant for him to stop it that he rarely did so.

When standing, if he wished to check the pendulum spasm, he threw the left leg back so as to trip the toe; the arm then fell in to the right as it moved and he brought the leg forward, catching the arm against the thigh. Then there was a general convulsive movement of the entire body and the limb came to rest.

When the arm was hanging at his side it began to move if he walked a few steps, or if he lifted the right arm, in which at times, especially after sudden arrest of the spasm, I noticed some large tremor. In all of this strange set of symptoms there was no loss of consciousness, no anesthesia, no speech or ocular trouble, no aural defect. When he walked long or fast the legs had some disposition to become rigid, but this was an inconstant feature.

The pendulum spasms continued unchanged up to October, 1876, when quite suddenly they ceased, and he began to have rotatory movements. The extended left hand and arm described a circle at the rate of 140 a minute or more. Later, the rate increased, but as they are fully described in Prof. Dercum's notes I leave to his account the details. Henceforward Connolly was subject to one or the other of these forms of spasms. Since August, 1895, he has had at times long periods of chronic contraction of the fingers of the right hand, relaxed when the member was held up above the head by an assistant, but this position gave rise to a wild convulsive motion in both arms. When an observer seized and firmly held the swinging arm, a general convulsion followed, involving in succession the other arm, face, neck and legs.

From the autumn of 1876 and thereafter, all movements ceased when he lay down, but recurred on his standing up, and were exaggerated by walking. If, however, when lying down he lifted his head, the left arm began to beat on the bed and did not cease until he stood up and then lay down again. Tapping the muscles smartly while he was supine caused no movements until the quadriceps tendon on the right was struck below the patella. The usual knee jerk followed, and then the left hand first and next the right flexed, and remained in spasms a few moments. A tap above the knee occasioned no such spasm.

Volitional effort at control made the spasm worse. At this period all the muscle reflexes were excessive, but there was no clonus. The skin muscle reflexes were present throughout and normal. All electrical reactions were normal.

There are some later notes in which he is spoken of as having at times pendulum movement and at other times rotatory motions. The tremor varies, comes and goes, and is chiefly in the right arm.

In 1896 and later he had sometimes for a month retention of the urine, and need to have the water drawn by catheter, but at no period was there ever cystitis or prostatic enlargement. There has been no retention of late, but at times he has had scanty urine, the quantity falling to six or eight ounces in the twenty-four hours.

In 1888 I turned over my patient to Prof. Dercum for study, and photographic records were made with the aid of Mr. Muybridge. As these photos do not help to understand the case any better than do Dercum's clear descriptions, I have not reproduced them in this paper but refer the curious to Muybridge's work on Animal Locomotion published in 1888.

After quoting my account of the case as seen in 1876, Dr. Dercum writes as follows:

"The phenomena presented have undergone some changes. The simple pendulum movement is now replaced by a more complex rotary movement, which is present only under certain conditions. Thus, when Mr. C. is sitting or standing still, the arm is carried in a semi-flexed position, while the hand and fingers are markedly contracted and in constant vibration. Were it not for this last factor, namely, the vibration, the position would bear some resemblance to that assumed by patients suffering from secondary contracture.

"If, however, Mr. C. attempts to rise or walk, the forearm becomes slightly less flexed, whilst the vibration increases both in amplitude and rapidity. If the walk be persisted in, and be it ever so slow and gentle, the forearm finally becomes completely extended, and now the entire arm describes a rotary motion, such such as is shown in the upper series of Plate 557.[2] It will be observed that this movement is one in which the hand, while it is suspended from the shoulder like a pendulum, describes a circle by first sweeping forward, then outward, then backward, and finally forward again to its original position. If now, while the arm is performing this peculiar movement, Mr. C. attempts to raise the arm up to the shoulder even the rotary movement increases wonderfully in extent. The arm describes a circle. The arm extended and the hand and fingers contracted, sweeps over a circle in front of the body. The hand sweeps upward and outward, and then inward again to its original position.

"At the same time that this spasm of the left arm is taking place the right arm, too, becomes convulsed. It is raised abruptly, and the forearm directed upward, and a series of to-and-fro movements begin, which examination shows are synchronous with the rotary movement of the opposite limb. As the rotating limb rises, the right arm rises; as the former descends, the latter descends. As the left arm sweeps inward and upward, the right arm steadily ascends; as the left arm goes outward and downward, the right arm steadily descends. There is certainly here a curious association of movement. If instead of raising the arm to the shoulder, Mr. C. simply sharply flexes the left forearm at the time it is rotating, a series of to-and-fro movements replace the rotary movements. That is, the left arm is thrown violently backward and forward. At the same time the right arm becomes similarly affected, and it, too, is thrown violently backward and forward. As in the previous experiment, the movements are found to be synchronous. It will be observed that at no time does the right hand become contracted and the fingers clawed."

Some idea may be gained of the rapidity of these movements when we reflect that the complete cycle of the movement occupied less than the half of a second (represented in Fig. 19),[2] while in Fig. 20[2] the rapidity had so much increased that the cycle occupied only the third of a second.

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[2] Animal Locomotion.

If Mr. C. is sitting quietly in a chair, with the arm in a semi-flexed position, already described, then lies down with his back and head flat on the ground, all vibration in the hand ceases. It becomes perfectly quiet, and he can execute with it most exact and delicate voluntary movements. If, however, he now attempts to raise the head, violent tremor at once appears in the hand. This tremor is so violent that the feet and head are affected. It is remarkable that the raising of the head is the only movement that provokes the tremor. Raising the right hand or either foot does not have any effect. Similarly, if he lies upon the ground, and the motion be completely arrested, it is again violently excited by striking the patellar tendon or by attempting to elicit ankle clonus. It is also a remarkable fact that the tremor so excited, or excited by raising the head, cannot be quieted unless Mr. C. arises completely from the ground and lies down anew.

I have seen Mr. C. from time to time since 1898. In these later years there was no change of moment, but he was certainly stronger, and when in the country walked five or six miles daily. The pendulum movement was not often observed, and the weakness of the legs never returned. The rotation action persisted, as described, until his death. In July, 1903, he presented symptoms of cardiac weakness, and was under Dr. Sinkler's care.

Increasing palpitation and shortness of breath occurred in October. November 11, after breakfast, he went to the water-closet and there suddenly died.

The treatment of this case is of interest. He saw many doctors and haunted clinics, and was variously treated with no good result. In December, 1897, I asked Dr. J. M. Taylor to hypnotize Mr. C. and use suggestion; a previous attempt by another assistant having failed. As usual, Mr. C. took a freshly hopeful interest in the new treatment, and kept a penciled, irregular record of the sittings and their results. For a long while it was impossible to induce the hypnotic state, but as Dr. Taylor writes me, after thirty sittings, of a half hour each, partial effects were attained. During these many sittings Mr. C. never passed into deep sleep, nor did he lose any sensory perceptions. Mr. C's notes state that after the seventh sitting he wrote a letter with his left hand and without tremor. On the twenty-third sitting the pendulum movements, previously very active, ceased for a few hours. This effect was obtained thereafter only at intervals during daily hypnotization. In January the sittings were more successful, and on the fifteenth sitting in that month all spasms ceased. He was able to take a place as assistant in the Jefferson College library, and for three months continued well, efficient and much liked for gentleness and amiability. Then something took place which excited him disagreeably, and at the same time he had influenza. The spasms returned in both forms.

While he was in bed, Dr. Taylor visited him, and was able to so influence him by an order that he could rise and walk about the room without spasmodic actions. It is interesting that after this he declined to be aided again by hypnotic means, declaring to Dr. Taylor that the hand of the Lord was upon him, and that he felt he should bear his trouble with a serene mind to the end of his days. Whether this was the result of a temporary mood or was one of the self-delusive states common in hysteria, I am not sure. Once, however, he allowed me to hypnotize him, with good results, which were not lasting, but after this would have no more of it nor give a reason except that it was disagreeable. Probably he missed the attention his case excited, for now again he began to appear at the clinics, but was unwilling to take any form of treatment.

It is needless to say that every other means of treatment had been sedulously employed, and that excepting hypnotic suggestion, all had failed.

On the day of death the post-mortem section was made by Drs. Eshner and Allen, with the assistance of Prof. Spiller, to whom was confided the study of the nerve organs.

REMARKS BY DRS. MITCHELL AND SPILLER.

Cervical region; sections from the lower part of the cervical enlargement of the cord stained by the thionin method, are normal. The chromophilic elements of the nerve cells of the anterior horns stain well. The nerve cells are pigmented, but not more so than is usual in a person advanced in years. The nerve cells of the anterior horns are numerous, and equally so in the two sides of the spinal cord. The white matter of the anterior, lateral and posterior columns is not degenerated. The anterior and posterior roots are normal. Anterior roots from the right side of the cervical region were cut separately from the cord, so as to obtain a large number for examination. These roots are perfectly normal. Sections from the mid-thoracic region are normal.

Lumbar region; the nerve cells of the anterior horns by the thionin method are like those of the cervical region, and are normal. The white matter of the anterior, lateral and posterior columns, and the anterior and posterior nerve roots are normal.

Brain cortex; sections were taken from the middle of the precentral convolutions of the left and right cerebral hemispheres. The nerve cells are numerous and well stained by the thionin method, and appear normal. No distinction can be made between the sections from the right and left hemispheres. Sections stained by the Weigert hematoxylin and acid fuchsine with hemalum are normal. The tangential fibers are numerous in all the sections from the cerebral cortex.

No signs of meningitis or of cellular infiltration are found anywhere in the brain or cord. The right precentral convolution is remarkably well developed, and more so than the left precentral. It would be well, however, not to attribute too much importance to this. All the convolutions of the brain are well formed.

The microscopical examination of the brain and spinal cord reveals nothing that could be regarded as distinctly pathological, and affords no explanation for the involuntary movements.

Remarkable, indeed, were the involuntary movements in the left upper limb in this case, persisting through so long a period, and it may at first thought seem strange to those who have not paid much attention to the pathology of the nervous system, that no lesions have been found to explain them, and yet we could hardly expect spasms that could be held in check for sometime by hypnotism to be dependent on organic changes in the nervous system. While we cannot cite a similar example with an equally long duration, we may refer to other forms of involuntary movements in which the findings have been negative. Numerous lesions have been found in cases of the so-called idiopathic epilepsy, such as sclerosis of the cornu Ammonis, the cortical sclerosis of Chaslin, the alteration of certain layers of nerve cells, etc. But all these lesions are of more or less doubtful value, and it is questionable whether they in any degree explain the convulsive movements. The epileptic spasms associated with unconsciousness and attended by alteration of the blood pressure, and possibly toxic conditions, are usually so severe that at least some, if not all, of the lesions found in epilepsy may be the results of a long succession of these serious attacks.

The pathology of chorea has not yet been determined if we except the form of Huntington, in which mental symptoms are prominent and the movements are only a part of the symptom-complex. We do not overlook the fact that certain lesions have been described as occurring in Sydenham's chorea, viz.: slight thickening of blood vessels, small hemorrhages, some round cell infiltration, "chorea-bodies," even micro-organisms, etc. The pathology of chorea, so far as it is understood, has been presented recently by Hudovernig, but we trust that we may be pardoned scepticism as regards the importance of these findings in chorea.

We should expect to be more successful in a search for lesions in convulsive tic, as this is in most cases a more serious affection than Sydenham's chorea, and yet, so far as we know, the pathology of convulsive tic has not been determined.

No organic changes in the nervous system have been discovered to throw any light on the nature of hysteria, even though involuntary jerkings or contractions have persisted a long time.

We might expect to find organic changes in the remarkable affection known as paramyoclonus multiplex. J. Meinertz[3] has described recently a case of myokymia, by which is meant contraction of muscle bundles, fibrillary contractions, without organic disease.

It differs from the paramyoclonus of Friedreich in that in the latter each affected muscle contracts as a whole. Meinertz suggests that in myokymia the nerve cells of the anterior horns of the spinal cord may be in a condition of increased irritability, and mentions that others have entertained the same view, and that Friedreich was inclined to attribute the involuntary movements in the disease described by him to this cause. Meinertz believes that this increased irritability of the nerve cells of the anterior horns may exist without causing any alteration that can be detected. Such a theory naturally cannot be refuted, nor can it be proved, and it seems almost improbable. An abnormal condition of nerve cells sufficiently intense to cause such pronounced movements of the muscles, would, in course of time, be likely to lead to organic changes detectable by the microscope.

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[3] J. Meinertz, Neurologisches Centralblatt, Feb. 1, 1904, p. 101.

Recently J. R. Hunt[4] has made a careful examination of the material from a case of Friedreich's paramyoclonus multiplex, and he mentions that pathological anatomy has thrown no light on the nature of this disease. No evidences of pathological changes were discovered by Hunt in the brain and its meninges or in the spinal cord. The nerve cells of the anterior horns and of the cerebral cortex were normal. The peripheral nerves, the intramuscular nerve fibers and the muscle spindles also were normal. The muscle fibers were increased in size, and sarcolemma nuclei were found between the sarcous elements. It is well to be cautious in attributing much importance to these changes in the muscles. Hunt refers to Friedreich's case in which the histological examination of the spinal cord and biceps muscle was made by Schultze. The findings were negative. This and Hunt's case seem to be the only examples on record of this type of paramyoclonus multiplex with systematic histological examination.

In Connolly's case the heart was the only organ which was plainly diseased, and it presented some unusual conditions, of which Prof. Allen Smith gives the following description:

"The heart when brought to me was in formaldehyde, already partially dissected. It weighed 400 g.; left ventricle, the special seat of enlargement, mainly from distension. Wall of left ventricle at base (the thickest part) 2.5 cm.; of right at corresponding position, 8 mm. Near the apex of the left ventricle on the superolateral convexity was an area a little larger than a dime, which externally showed white, and somewhat depressed as from a scar. The wall in this area is not above 5 mm. in thickness, dense and fibroid to palpation. Corresponding to this area and for a considerable zone about it the endocardium, involving that of the pectinate and papillary muscles, is white, opaque, and at thickest part as much as 2 mm. thick. In dissection of the coronary artery to this part its wall was found generally thickened and fibrosed, and is lost as a tiny thread-like branch in the cicatrix (not cut lest connection be lost, but apparently solid). The wall of the ventricle in the entire apical portion is decidedly diminished, on an average about 8 mm., while with a rather abrupt border toward the base the above excessive thickness is reached. Muscle toward the base is apparently normal as far as gross appearances are concerned, in the thinned area it is paler and firmer than normal. The sheets of the aortic and mitral valves are decidedly sclerosed and opaque, those of the aortic opening showing advance of sclerosis from base toward free margin. Valves of right heart and endocardium of cavities normal. Cardiac openings not estimated because of their previous section. The aorta in coronary sinuses about arterial openings and along attachments of aortic cusps, shows slight patches of advanced atheroma.

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[4] Hunt, Journal of Nervous and Mental Disease, July, 1903, p. 408.

"Microscopically sections through the wall, close to the dense cicatrix, show the pericardium and endocardium much thickened, and the latter in places very dense and hyaline. Slight fatty infiltration in the pericardium. The myocardium in places is almost completely cicatricial; but much of the several sections shows the presence of muscle bundles surrounded by a large amount of connective tissue. Some of these bundles are apparently normal; many atrophic, with the primitive fibrillæ lost and the appearance that the primitive bundle extends directly into the connective tissue of the scar. The idea is given of the existence and marked thickening of a sarcolemma sheath about the primitive bundles, and of septa within the bundles separating the ultimate fibrils. The loss of muscle substance leaving these elements behind, apparently, occasions the appearance of metaplasia just mentioned, in a passive way, however. Such apparent remnants stain as connective tissue with Mallory's special connective tissue stain (not absolute, as formaline was used here as a fixative), and so too transverse sections of what seem to be atrophic primitive bundles stain in sheath and in the interior in the same way. In the cicatricial tissue may be also seen remaining nuclei of former muscle bundles, sometimes in some state of disappearance as in solution, again intact, and then often with a somewhat spindle-shaped mass of protoplasm about them, as if forming a large young connective tissue cell, staining with the above special stain as connective tissue.

"No direct continuation of these cells into fibrillæ of connective tissue could be seen; no evidence of the multiplication of the nuclei of these bodies; numerous retrogressive forms, and often isolated granules of polar pigment indicating the previous position of the nuclei. For these reasons it is concluded that no real active part in regeneration into connective tissue of the scar is borne by these cell-like remnants. In other portions of the heart muscle the usual moderate interstitial fibrosis is seen. The muscle substance is in its degeneration near the scar, the seat of a liquefying process producing large vacuoles in its substance; and here and there finer vacuolation suggests the existence of fatty degeneration. The vessels are generally more or less fibrosed."

We feel that this case requires little comment. No one would hesitate to label it hysteria. The psychical picture is complete. The mental peculiarities, the motor phenomena, the vesical symptoms, the one form of therapeutic success are all characteristic.

Both Dercum's notes and our own comments dwell upon one striking feature, the fact that certain positions, passively caused or voluntarily produced, gave rise to definite extension of the spasms to the quieter arm and at times to the entire body.

This phenomenon is of great interest. Dr. Dercum speaks of it as like an overflow of nerve force, and it recalls to mind the explanation of the effects of reinforcement of keen jerks given by Drs. M. J. Lewis and S. Weir Mitchell.

We are tempted to ask if restraint of the affected arm during a fit of Jacksonian epilepsy will be found to cause extension elsewhere of the limited convulsive motions. It seems probable that such restraint during a Jacksonian attack would have a tendency to cause extension of the convulsive movements to other parts of the body, because in epilepsy the muscular convulsion appears to act as a release to excessive energy stored up in the cortex. Restraint of the spasms in epilepsy sometimes is followed by sensations that are more unpleasant than are the spasms, thus Gowers remarks: "The arrest of the fit, by a ligature or a blister, sometimes causes so much giddiness and distress that some patients have considered the remedy worse than the disease."

In this present case the increase and spread of spasms by restraint of the primary spasm tempts to speculative hypothesis, but the physiological mechanism is under no theory clear. If one could damn up explosive nerve energy in its originative center until it overflows its normal nerve channels and sweeps over many neural centers and channels in disorderly discharge, this is conceivable. But when these outbursts are evoked by lifting a limb or restraining an habitual spasm at a distance from the center of effluent energy, the reason of the wide extension is not easy to explain. For in the case of a spasm forcibly checked we are only limiting the degree of disorderly muscular discharges, and not the primary outflow of nerve force.

This very interesting fact of restraint of spastic motion causing remote, or even general spasms, is not single in the experience of one of us.

Dr. Mitchell saw, in the Civil War, a soldier who had a see-saw spasm of the left foot, caused by a nerve wound of the sciatic. The flexors and extensors acted by turns, so as to keep the foot in constant motion. When it was held firmly, the man was seized at once with a general left-lateral convulsion, in which the face moved but slightly, without ocular spasm or loss of consciousness, but with occipital pain. As soon as the foot was released the other motions ceased. Sensibility was impaired from the peripheral lesion.

In the case of Col. P., described on page 364 of Dr. Mitchell's book on nerve injuries, there was a continual irregular threshing motion of the arm stump, which ceased for a time, when the stump was exercised in voluntary motion, but which extended over a large region of the same side (right) with a sense of discomfort in the head if an attempt were made by another to restrain the spastic movements in the stump.

The purpose of this paper is to give the result of minute pathological study of an uncomplicated and lasting case of undoubted hysteria.

The conclusion justifies us in stating that with our present methods the most typical hysteria lasting for years, presents no sign of representative organic lesion. This is, however, the wisdom of to-day; that of to-morrow may be based on other and more refined methods and be very different.

The case has other than this merely negative value. It raises the question of why restraint causes generalized spasm. It suggests consideration of the share which even hysterical mental attributes many have in this sequence, and it illustrates how large and how lasting may be convulsive symptoms without their leaving a record on the long disordered centers whence came this overflow of energy without sign of fatigue.